Ethical issues in working in counselling and psychotherapy in small rural communities

RAISING ETHICAL ISSUES IN COUNSELLING

Counselling in Scotland

SUMMER 2010

Fit for work?
New government legislation.

What does the public think about therapies?

Getting it right for every child.

Dyslexia and Mental Health
(exposing its poisonous roots)

Ethical Issues in Working in Counselling and Psychotherapy in Small Rural Communities

From Sick Note to Fit Note: Implications for Workplace Counsellors

Getting it Right for Every Child: Scotland's Vision for All Children and Young People

Public perceptions of the credibility and usefulness of CBT, Person-Centred Therapy and Counselling

Cosca Module 2

COSCA
Counselling & Psychotherapy in Scotland

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Gazette

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Editorial

John Dodds

It's been my hope to have themed issues of the journal. And, although this hasn't ever happened through conscious effort it often comes about almost by default. And by the good offices of Brian Magee, who does most of the chasing to get articles in for Counselling in Scotland (thanks, Brian!), this time around, it so happens that questions about ethics weave through a number of the articles.

Working as a counsellor in Edinburgh, I was always aware that I might encounter clients in the street. Although it never happened, several of my clients said, "If we bump into each other, it's okay to say hello." But unless a client acknowledged that specifically I would always choose to respect counsellor-client confidentiality outside of the counselling room.

While cities like Edinburgh and Glasgow are often described as a series of small communities grouped together, the ethical issues raised by working in small rural communities is discussed in a fascinating transcript of a speech made by Seamus Prior at COSCA's 2010 ethical seminar. It makes many useful points that counsellors (whether you work in a small rural area or in a city) may find enlightening.

Ethical considerations are also raised in Rachel Weiss's piece about new legislation which replaces the "sick note" with what's being called informally the "fit note" in the workplace. Rachel says there are benefits and pitfalls. Much as there was when unemployment benefit was replaced with "job-seeker's allowance." Not only do we as practitioners have to wrestle with the new terminology, but we need to understand clearly what it means for our clients and those of you employed as counsellors within, or by, organisations.

Robert McCormack's article about dyslexia and mental health was of personal interest. My father was dyslexic, but became an adult learner only a few years ago. He found (at the age of 74) that he could actually read and write, in spite of what he believed. That there were techniques and approaches that could not only benefit him educationally, but also emotionally, and socially, was something he wouldn't have believed possible before. And dad would have certainly related to the issues Robert talks about in respect of people growing up with dyslexia.

Finally, a note about John McLeod and Andrew Sweeting's summary of a recent study into public perceptions of different types of counselling. While it's good to know that the small body of research into counselling is showing signs of growing, this research interviewed only 28 people. John acknowledges himself that the sampling is not large enough to represent the population of Scotland. On the other hand, some of the questions it raises could form the basis for a more substantial piece of work. It was interesting to see, for example, the extent to which those interviewed were influenced in their perceptions by the media and even the way experts described in writing different therapies. One interviewee described a sentence in one description as "patronising". Reading the quoted sentence, I could see why. I recall one of my peers on the counselling training course saying that some people were put off counselling by the idea that the counsellor just sat with the client, not speaking, head tilted to one side and "nodding sagely."

Let me conclude by thanking the authors for their excellent work, and sign off (nodding sagely as I head into the sunset).

Dyslexia and Mental Health

exposing its poisonous roots

Robert McCormack
Disability needs assessor and counsellor

Although it has long been hypothesised that dyslexia, stress and anxiety are correlated, it came as a surprise to me to find that not much has been written about it. Experience has led me to believe beyond any reasonable doubt that stress rides comfortably in the slipstream of dyslexia. I have yet to meet a dyslexic adult whose life has not been dominated by stress. I have personal experience of working with dyslexia in prisons, secondary schools, further and higher education establishments, and in the public, private and voluntary sectors. In addition to this I have been involved in the development of educational programmes for dyslexics, such as the Colourfield Programme and Wired for Success (WFS).

My current role as a disability needs assessor and part-time counsellor has allowed me to expand my exploration of the emotional factors and the serious challenges they present to students daily.

What is dyslexia?

In order to identify some important connections we should start by asking what dyslexia is. While most people have heard of dyslexia, it is not a term well understood, mainly because dyslexia is a complex constitutional condition that results in differences in some aspects of information processing in the brain. Most figures quote that it affects between four and 10 per cent of the population, yet very few people are assessed and given the appropriate support. This is thought to leave a huge nucleus of undiagnosed dyslexia in the population.

Although there is no universally agreed definition of dyslexia, the neurological bases of dyslexia are now well established and reflected in current definitions of the condition. The following working definition of dyslexia has been developed by the Scottish Government, Dyslexia Scotland and the Cross Party Group on Dyslexia in the Scottish Parliament. This is one of many definitions available. The aim of this particular working definition is to provide a description of the range of indicators and characteristics of dyslexia as helpful guidance for educational practitioners, pupils, parents/carers and others. This definition does not have any statutory basis.

Dyslexia exists in all cultures and across the range of abilities and socio-economic backgrounds. It is a hereditary, life-long, neurodevelopmental condition. Unidentified, dyslexia is likely to result in low self esteem, high stress, atypical behaviour, and low achievement.

Learners with dyslexia will benefit from early identification, appropriate intervention and targeted effective teaching, enabling them to become successful learners, confident individuals, effective contributors and responsible citizens.

A study in Germany examined the phonological processing in dyslexic children using FMRI scanning and concluded beyond doubt that dyslexics do think differently when reading; *Dyslexia Science* (2005). However, dyslexics are not required to negotiate the differences in brain chemistry on a daily basis; it is the psychological and social effects they have to deal with... the poisonous roots, if you like. I consider that in many ways secondary symptoms are as educationally revealing as primary symptoms, and may lead the way towards the development of categorisation systems based on underlying causes rather than obvious symptoms. The reason for this is that identifying the secondary symptoms can help us to identify the underlying causes. This can help expose the hidden elements of dyslexia and present the person with an accurate profile of their difficulties.

The psychological and social effects of dyslexia (the poisonous roots)

The problems of dyslexia can often extend well beyond the common difficulties with reading, writing and spelling, and the psychological side-effects can be far-reaching.

It is often said that our school days are the best days of our lives, but try telling that to a dyslexic! Imagine what it would be like if you were afraid of going to school every day, terrified of being humiliated and shown up in class. You have difficulty with reading, problems with spelling and handwriting; you have a poor short-term memory and expressing yourself verbally is a challenge. Every part of your school day, from class work to communication with teachers and peers is difficult. And what if no one takes any notice? What if other kids keep calling you "stupid" and think it's justified because they've heard teachers say it to you many times? This is often the experience of young people with dyslexia. Some cope better than others. Some teachers and schools are better equipped to deal with it than others, but in many cases, the frustration of struggling with reading, writing and spelling can lead to feelings of embarrassment, humiliation and low self-esteem.

Humiliation causes resentment which can lead to challenging behaviour, a tactic often deployed by dyslexics to avoid the experience of repeated failure. Common sense dictates that children who are subjected to humiliating experiences may respond with resentment or anger. As noted by Scott (2004), dyslexics tend not to have the route of verbal expression open to them as a means to express their anger.

Fawcett (1995), writing about the varying effects of stress on children and adolescents, comments that they will react to stress in a variety of ways, dependent on their personality or temperament. Case studies include examples of hair and weight loss, blinding headaches, a devil-may-care response and confrontational behaviour used as a smokescreen to mask their difficulties. As well as the factor of temperament influencing how an individual responds to a stressful school environment, socio-economic circumstances will have a crucial influence on the young dyslexic's chances of success. Fawcett goes on to add: "The suffering that is endured in the current school system and the attendant psychological scarring is hard to quantify, but it impacts on the motivation, the emotional well being and possibly the behavioural stability of the dyslexic".

Fawcett's findings certainly resonate with me as they correspond with my own experience. Dyslexia accounts for 60 to 80 per cent of my referrals. Unfortunately, very few students have received a diagnosis or have had access to appropriate support in school. It seems that we are picking up the casualties that the schools leave behind as many are unaware that dyslexia is the source of the extensive problems they are facing.

The counselling process

Most of us experience stress at some point in our lives, but experience suggests that dyslexics are particularly vulnerable to it.

Although we cannot cure dyslexia, this is simply because it is a human difference. We can however cure the emotional and psychological effects of dyslexia, and counsellors are well placed to do this. This can be achieved by enhancing the therapeutic relationship between dyslexic clients and counsellor by facilitating better communication and a deeper understanding.

This is counselling based on a deep understanding of what the world looks like through the eyes

of a dyslexic, as without this knowledge the counselling process cannot move forward.

Let's look at the core conditions of person centred counselling.

Unconditional Positive Regard (UPR)

The counsellor accepts the client unconditionally and non-judgementally. The client is free to explore all thoughts and feelings, positive or negative, without fear of rejection or condemnation.

Points to consider

Outside of the family home, dyslexics may have never experienced UPR. They have been unfairly judged, condemned and rejected most of their lives.

Empathy

The counsellor accurately understands the client's thoughts, feelings and meanings from the client's own perspective.

Points to consider

When the counsellor perceives what the world is like from the client's point of view, it demonstrates not only that the view has value, but also that the client is being accepted. The counsellor must be able to pick up accurate integral feelings and communicate the affective awareness back to the client. This can be problematic at times with dyslexic clients, as they may hear in a functional sense but not in a cognitive sense.

Counsellors may be prevented from entering the dyslexic client's framework if they do not understand the processing filters that their communication has to go through. I would recommend building in a time-delay here; this would allow the client time to unpack what the counsellor has said, study it, comprehend it and work out a response.

Congruence

The counsellor is authentic and genuine. The counsellor does not present an aloof professional facade, but is present and transparent to the client. There is no air of authority or hidden knowledge, and the client does not have to speculate about what the counsellor is 'really like'.

Points to consider

Many dyslexics have profound difficulties with relationships. They can become socially phobic, defensive and distrustful of others. What they need most in life is congruence; unfortunately this is what they receive the least of. According to Scott (2004), "The story of a dyslexic's life is a catalogue of incongruence. It started with those odd bright smiles and insincere praise in overloud and overhigh voices at school and home. It continued when powerful people insisted that strange shapes on paper made a sound when clearly they did not. It carried on through the constant and inexplicably failed encounters with people who rejected them despite every effort to please".

These difficulties may become apparent in the therapeutic relationship; congruence is a gift – and one that counsellors and therapists know better than anyone how to give.

What works well with dyslexic clients?

As dyslexia is best understood and located at the cognitive level, cognitive behavioural therapy (CBT) works extremely well when applied to the negative introjects and anxiety-based thought patterns of dyslexics. CBT is based on the scientifically supported assumption that most emotional and behavioural reactions are learned.

Therefore, the goal of therapy is to help clients unlearn their unwanted reactions and to learn a new way of reacting.

Dadds and Barret (2001) in their review of young people with anxiety disorders concluded that brief CBT treatments for anxiety disorders in children and adolescents are highly effective and emphasise that such interventions are effective for long-term change.

Conclusion

Good dyslexia counselling is no different to good counselling in general. The therapeutic relationship can also be a refuge for a dyslexic client 'the shielding influence of a good relationship in the midst of discord and disharmony' (Rutter 1985 pg 359)

An effective counselling system should make intelligent, integrated use of all parts. One part in isolation is always less effective than the whole. For example, counselling work alone aimed at enhancing self esteem or stress reduction will have a limited effect. Pumphrey (1979) found that even direct literacy instruction had more effect than counselling alone.

An integrated working model should include the following four stages:

1. Assessment: assessment carried out by an educational psychologist
2. Post diagnosis: counselling; feedback and breakdown of report; help with jargon of report
3. Feedback is the most important part of the assessment process. The client must leave with a greater understanding of the nature of their difficulties and what can be done to overcome them.
4. Literacy and study skills support: literacy support; alternative learning techniques and coping strategies; information and communications technology (ICT) exploring assistive technology applications.

Counselling: a natural extension of the assessment process

The counselling process must adjust to the client's dyslexia. Through time and with the appropriate training the counsellor can then move from conscious competence to unconscious competence. Dyslexia Scotland is an excellent organisation that is well-placed to support counsellors and psychotherapists.

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Ethical Issues in Working in Counselling and Psychotherapy

in small rural communities

Seamus Prior

Talk given at COSCA's Ethical Seminar 2010, 'Counselling and Psychotherapy with Small Communities (place and interest)'. It took place in Dunblane on 22 February 2010.

The presentation which I have prepared for you today is "Ethical Issues in Working in Counselling and Psychotherapy in Small Rural Communities". I was given the particular brief of trying to pull in the research that is in this area but you may not be hugely surprised to know that after significant literature research by me and some of my PhD students there isn't very much research available. We have found some, perhaps connected more obliquely to the topic, which I'll be able to bring in as I am speaking today.

I would like to pick up really on some of Fiona's [Fiona McColl, Chair of COSCA's Ethics Committee, an integrative and holistic counsellor, and a COSCA accredited trainer] points from the beginning that actually we all live and work in small communities. People may have heard some recent research on anthropology, which says that the vast majority of people still know the same number of people as man or woman did millennia ago, which is around 150 to 200 people. That's about the maximum number of people that any one person could possibly know at any one time. So even if you live in Mexico City where there's 32 million people you are likely to be moving in small communities of tens, twenties, thirties and forties, and have a maximum in your life of about 150 people.

Rural communities are very complex. Sometimes we think we know what we mean when we say "rural community" but if you think about it, a small village on the outskirts of Bathgate, West Lothian, in easy commuting distance of Edinburgh, Glasgow, Livingston and with all kinds of history to do with mining and post industrialisation, it's going to be a very different place from Scourie, a crofting village up near Cape Wrath in the North West corner of Scotland. There would be a completely different history and culture. There would be a completely different connection between people and people will actually live in very different set-ups, cheek-by-jowl to each group, although actually quite distant from each other. So while there will be similarities with them both being rural communities there will be really significant differences. So it's important that we don't generalise.

Similarly communities: what is our definition of community? Now, I could have looked up the books but I just decided to give my own definition of community which is something like a group of people who relate to each other, know each other to a greater or lesser extent, with some sense of shared purpose and possibly common identity, but all of that is possible to a greater or lesser extent between communities.

As Fiona said, there are communities of identity. The most obvious ones are things like ethnicity, or like myself. I am myself from what I call an Irish exile community living in Scotland, that's how I choose to define it. Other Irish people might call themselves something quite different but that's a community I belong to which is a minority community in Scotland, although not often seen as such. So it's interesting, all of those complex ideas already around with me just mentioning that I'm Irish living in Scotland. There are communities of faith, there are communities of disability, there are communities of politics, there are sexual minority communities, commonly called LGBT (Lesbian, Gay, Bisexual, Transgender). There are lots of identity-based communities although within them there will be lots of people who do not choose to call themselves that identity, or call themselves a quite different identity and can have quite ambivalent relationships about belonging to those

communities in that other people would define themselves quite simply as obviously belonging to those communities. But, as Fiona's mentioned, there are workplace communities. There are factories. I used to work in a factory – Mercedes Benz in Germany. There was a really strong community in that factory where people socialised together, spent lots of time together, kids all played sports together. It really was like a family you know, and there are plenty of workplaces and professions like that and those of you involved in counselling training will know we often call our training groups training communities, or student communities, or participant communities. So, there's a sense to which being a counsellor or being a counselling student is also being part of a community.

And of course there are hobby communities. There's the Hibs fan; I live around the corner from Hibs and there are lots of people that live for Hibs just as they live for Rangers and Celtic and for lots of other sports and activities. So there are all kinds of communities, and Colin [Colin Kirkwood is a psychoanalytic psychotherapist in private practice and former Convenor of COSCA] will come on later to talk about a specific community which is a therapeutic community or an in patient community because that too is a group of people living in hospital together, whether by choice or compulsorily detained, who are effectively a community while all together.

As I go into talking about working with people in smaller rural communities I want you to have in mind an image of a circle because the way that I see this as quite helpful. It is that the counsellor is the guardian of the boundary and the space in the middle is the space for the client to do the work, and the counsellor's job is to try and keep that space within that circle as free and as uncluttered as possible so as to protect the outside world coming into that space. But equally the counsellor's task is to keep that boundary quite tight to protect what is done in that space. So they are the guardian of a boundary to protect both things coming into it and things going out of it. And I think it would be fair to say that the more troubled the client is when they are coming in the door the more they will need to perceive the robustness of the boundary. Now you may feel that the boundary that you draw is robust for every client but there will be some clients that need to know how robust that boundary is and also there will be some clients who live and work in small and tight knit communities, and maybe who share similar community identities to you, who also need to know quite how robust that boundary is.

How do you practically address maintaining that boundary? I think you'll all know this but there are some very obvious things. Like we maintain the identity of the client as a client in privacy, so that we manage the way they come and go when they see us. We don't have five clients lined up in the waiting room at the same time. We all happen to work in the same community and so we avoid that as much as possible although it's not always 100 per cent possible. People may turn up early or turn up in an emergency and see someone else. So there are boundary crossings at times but most of the time we try and plan the way people come and go to see us whether in agencies, private practices or hospitals such that they don't cross over.

We try and maintain the confidentiality as much as possible outside the boundary, and that's why we need to have a clear conceptualisation of what is supervision and what our conversations are about. In our training, we use an excoriating piece written by Faye Weldon about a group of Jungian analysts in London who spent all evening at dinner talking about their patients in her

company, and she said if this is what they must do I don't think I want anything to do with this profession. While we may console ourselves that we would never do that, I think we've all been party to conversations about tricky things at work with colleagues where sometimes we may say a little too much. So I think we have to be very mindful what is supervision and what is general offloading or dealing with the strains of work, etc., in terms of maintaining confidentiality. But another key way of keeping that boundary tight is being and remaining a stranger to your clients. Now you may find that quite a strange thing to say but in some research I've been doing with youth counselling, the key thing that the young people say is that one of the most important things that helped them go to see the counsellor and stay seeing the counsellor was the fact that the counsellor was a complete stranger. She doesn't turn up at assembly, she doesn't turn up for the maths lesson, she doesn't turn up to the groups or the sports. She is in that counselling room, they go and see her, they work on their issues there and they don't ever see her the rest of the time. And that's one of the key things that comes out of research with young people. I can't say it's the same for all clients, but certainly for young people it is very important to them that the counsellor is not known to them and does not have a dual relationship with them.

Dual relationships have traditionally been considered as something not appropriate at all in a counselling or psychotherapy role, and you'll all know this. Personally I think the shadow of sex looms over dual relationships. There is a fear of sexually inappropriate boundaries between therapists and clients, and while again we may console ourselves that we are all now so used to codes of ethics that this doesn't happen, research tells us that it happens time and again and it is continuing to happen. Some of the strongest research is actually from the US, rather than here, which shows that there is still a shockingly high percentage of sexual boundary violations between, I'm sorry to say to the men in the room, senior male therapists and female clients, usually but not always, but this tends to be the actual data. So that is still happening and BACP reports that the majority of complaints that they've seen are due to inappropriate behaviour between therapists and clients. So that's still going on. The shadow of sex still lies over the whole issue of dual relationships, I would say, and is still an ongoing problem related to our work as counsellors and psychotherapists. COSCA has a new statement about dual relationships which you can get on the COSCA website which tries to address some of these issues in an open and helpful way.

There's been a recent alternative view from Lynne Gabriel who has written a book called *Speaking the Unspeakable* in which she has done some research from people working and living in small communities where she very helpfully says: "well, actually sometimes you have no choice". Sometimes you have to be in a dual relationship when you live and work in an island community or in a very small community up there in the islands or somewhere like that where you will inevitably be crossing paths with your clients in other ways. Lynne Gabriel also argues that counsellors, to some extent, are really averse to the idea of dual relationships because they have been frightened and inexpert at doing common ethical practice, and making ethical judgements. She talks about the importance of what she calls ethical literacy which is like emotional literacy: the idea is that you get used to dealing robustly with ethical issues in your relationships with clients and with others. One of the best examples I think of moving to a different relationship after counselling is Kim Etherington's work with two brothers that she worked with and that she then entered into a collaborative research relationship

with afterwards. She's written a whole book about it and lots of articles on this for anyone who's interested. But she really did painstaking work about power and authority, about how they move from being counsellor and client into co-researchers together about work they have done and the themes that they have worked on and I think that's a good example of just how painstaking we need to be if you intend to form a different kind of relationship with your clients after you've finished counselling them. One of the things we put in the COSCA statement is you must be mindful that you remain an important person in your client's life and just because you say, "oh that's the end of therapy" doesn't mean "now we can be friends, now we are equals". Actually, it's much more complicated than that and it needs to be really thought about and borne in mind.

On a practical note I have sometimes found it very useful, if I'm hearing information from a client where I think, "Mmm, I may well be meeting this person somewhere", because there are things they are telling me about their lives that seem to be crossing with my life. I find it quite practical to actually note that very loosely at the end of the session and simply say something like "you know it's possible that our paths might cross this way or that way" and to negotiate with them what might happen if that happens because, I don't know if you've had this experience, but I've had the experience, both as a counsellor and a client, of that frozen moment when your client or your counsellor walks in the door of that party, or the business thing that you're at, or whatever it is. It's good if you think that's a possibility that you actually check that out and negotiate it but lightly; you don't make it a big issue because, after all, a client is there to work on his or her issues rather than yours. So it needs to be worked on lightly. I think it's interesting, I live and work in Edinburgh, Fiona lives and works in the Borders and she's already highlighted some of the complexity of the multiple roles that I'd like you to think about – there's Lynne Gabriel arguing about dual relationships being sometimes completely unavoidable, sometimes completely necessary or completely beneficial to clients and counsellors, but are there some dual relationships that can't work, putting aside the sexual ones? And are there are some roles that you can't occupy in your small community? Could you be the barman at the village bar, or barwoman, and also be the village counsellor? Can you be the local MSP, or councillor, and also be the local counsellor? Can you be a minister, religious leader, or a community leader or a community development leader and also be a counsellor? Now you might think that you can, and you may be able to negotiate that, but you do run the risk of inhibiting your client's capacity to really open up to you, because of what I mentioned earlier about being the stranger in their lives and not popping up unexpectedly. So, I think there's a real tension for anyone who is in that kind of situation.

One of the core ethical dilemmas here, and Fiona has already mentioned it, is what happens when you identify other people in the client's story. Now personally I found some ideas from phenomenology quite interesting in this field. We are there to work with the client's subjective experience. We are there to work with their life and their perception of their life. We are there to work with their phenomenology and their truth. We are not there to work with the truth. And we are not there to bring our conceptions and what we know about that situation or that context or those people into the room and we need to bracket that off. That's the idea that I found particularly helpful from phenomenology. It's that you clock "it sounds like that situation that I know something about" or "that's that person I think I know something about". It's about finding a way to bracket it off, hold it in the background, and work with the person in front of you.

I suspect that in the course of about two years I have worked with two students and one lecturer who all had a massive conflict together and actually I never found out during the course of working with the three of them whether or not it was really the others who were involved and to this day I still don't know. A little bit of me thinks it's possible that they did but I heard three completely different stories about the terrible conflict on the course. And I worked successfully with all three people and I can say to this day I did a good piece of work, and it didn't perturb me too much that I thought I might know some of the other people they spoke about – so it's about knowing and choosing not to know at the same time. I think you have to be very careful about disclosing any knowledge you have because of this idea about keeping the space free. It might be that the best and most honest thing for you to do is say to the client "oh by the way I know about this person you are talking about" or "I know about this situation", but it does have the potential then to inhibit the client. So you have to think very carefully about doing that. After all you have to protect that space for them to do the work that they have to do. And most importantly, you have to think very carefully if you are deciding to stop work with the client because of an ethical issue. The key ethical issue here is not our comfort, but it's minimising the disruption of their therapeutic process. So if we're finding actually that this boundary is too close and it's unethical of me to continue work with this person, then we have to really plan in supervision how we might bring that relationship to an end without overly disrupting the client's process, because the client will almost certainly be feeling rejected or unwanted or feel they have said something wrong or disclosed too much or something like that, and that's why you are showing them the door. So, I think we must treat that very carefully and work with this in supervision.

Just another couple of things. In identity communities there are as many people that don't want to work with the counsellor with similar identity as do, and I think it is really important to have that in mind. We can't always assume that because someone is of a certain ethnicity they will definitely want to work with a counsellor with the same ethnicity or similar identity. It is often the case that they do not want to work with someone of the same background as them.

There are real pros and cons in this area of shared community membership working with clients. One of the pros is obviously that one might have some of their experience which provides the capacity for empathy. One of the disadvantages is potential over identification – "I've been through this too" – because their experience may be quite different. I know that Colin will want to talk about this later so I'll just finish on a couple of further points that I know he's picking up on. One is I think we need to bear in mind that clients live in communities just as we do and there are wider contexts we need to have in mind. There are particular group dynamics and work place dynamics and organisational dynamics that we need to be aware of when working with people and there are potential pitfalls like scapegoating, "in" groups and "out" groups.

Finally, we also need to be mindful about when we might need to take an issue out to the community, because it's persistently coming up in the client work. Some examples might be a bullying workplace culture, everyone you are getting from the same workplace is telling you that they are being bullied one way or the other or a lecturer of a department with his common sexual harassment of students. Can you still keep holding on to that and working with one student after another or a minister or a priest alienating their congregation? If you have one after the other coming into the counselling service telling you

this, obviously you have to protect confidentiality, but if you are working with such a community, you have also to do something about it.

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From Sick Note to Fit Note

implications for workplace counsellors

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On 6 April 2010 the sick note was replaced by the *Statement of Fitness for Work*, or "fit note". This is part of a wider government strategy to improve health and wellbeing for the working age population.

For this article I spoke with general practitioners, occupational health, human resources (HR) professionals and workplace counsellors to discover the potential benefits and pitfalls of the new fit note. I then considered what impact the fit note may have on workplace counsellors.

What's changing?

The old sick note only allowed doctors to say whether the patient should or should not work. The new fit note means doctors can advise that the patient is either

- Not fit for work
- May be fit for work, taking account of the following advice

Doctors can now advise how a return to work can be facilitated. It is useful for workplace counsellors to be familiar with the four most common recommendations, mentioned on the Statement:

Phased return to work: reduced hours, gradually increasing to normal hours over a period of time.

Example: One of my clients was off with depression. After four weeks of counselling she met her manager and returned to work three hours a day for a week, gradually increasing her hours. The client had thought she was ready to return full-time, which I knew this can be exhausting. Fortunately the client's manager was aware of this too and their HR policy was that employees should always have a phased return after any absence due to mental health issues.

Altered hours: different hours, not necessarily fewer.

Example: A client's wife had manic depression. They had three school-aged children. He wanted to return to work, but was always worrying what his wife was doing and whether the children were OK. When I asked when it had been easier to combine work and caring, he said the best had been when he worked night shift. So he decided to ask work whether he could do night shifts again, even on a temporary basis, to enable him to return to work sooner and to stay at work.

Amended duties

Example: I've seen several clients who are train drivers, off work after running someone over on the tracks. They have initially returned to amended duties for example, being in the station office or sitting next to another driver on a train.

Example: A client working in a bank was off work with stress. When she returned they initially gave her less stressful duties, such as not dealing with customer complaints or training.

Workplace adaptations

Example: One client felt very bitter and resentful towards a colleague who had got a job she had applied for. The seating arrangements at work were changed so that she was no longer sitting directly opposite that colleague.

The employer must consider the doctor's recommendations and decide whether they are practical or not. If not, then the employer is considered not fit to work.

Why is it changing?

In 2007 Carol Black, National Director for Health and Work was commissioned by the Secretaries of State for Health and Work and Pensions to undertake a review of the health of Britain's working age population. Her report states:

"Recent evidence suggests that work can be good for health, reversing the harmful effects of prolonged sickness absence. Yet much of the current approach to the treatment of people of working age, including the sickness certification process, reflects an assumption that illness is incompatible with being in work." [p.9]

"Early, regular and sensitive contact with employees during sickness absences can be a key factor in enabling an early return". [p.11]

"Recommendations: The sick note should be replaced with a fit note, switching the focus to what people can do and improving communication between employers, employees and GPs." [p.17]

The new fit note is a direct result of Black's report. The Scottish Government's Healthy Working Lives strategy includes a response to Black's report and aims to improve the health of the working-age population [HealthWorks]

Potential benefits

The professionals, whom I interviewed, echoed the points made by Black above:

Encouraging dialogue: One occupational health professional felt that the sick note now puts more onus on the employer to conduct return-to-work interviews and have a proactive sickness absence policy. Employers are often frustrated at simply receiving a sick note saying the client is off work, without specifying when they are likely to return or what support they need to do so.

Enabling clients to return to work sooner: "Attending work is largely regarded as good for mental health and wellbeing. The Fit Note has the potential to reduce absence due to illness or incapacity by taking the opportunity to find out what the employee can do to remain at or return to work provided there are appropriate support mechanisms in place for this to happen" (Rick Hughes, Lead Advisor: Workplace, BACP).

In cases where a return to work would be detrimental to the client's wellbeing, the doctor would choose the "not fit to work" option.

"The new fit note is designed to encourage a speedier return to work and gives greater flexibility for return to work arrangements that suit both employer and employee.

"It is also no longer necessary to be signed off as fit to work. This means that, with the employer's permission, the employee can return to work or resume their full duties (without any adjustments) before the date stated on the fit note." Nicola Harcus, Corporate Services Manager, Servite Housing Association

Improving employee mental health

"As far as employers are concerned, the Fit Note is a long awaited and welcome step in the right direction in terms of absence management. The benefits apply to the employee and employer. The outdated Med 3 form did not allow for the fact that injury or illness does not always render the employee completely incapable of work. More often than not, the employee is capable and also keen to return to work in a temporarily adapted role. Research has demonstrated time and time again that employment is good for us! The social interaction and feeling of contributing to society associated with employment are just two factors which can contribute to our feelings of wellbeing

and self-esteem. Research has also shown that the longer an employee is off work sick, the less likely they are to return to work. I have seen people lose confidence, feel isolated and become depressed after mid to long-term spells of absence from work. The Fit Note allows employers the option to discuss with the employee much sooner than the normal timescales would allow." Christine O'Ready, HR, The High School of Dundee.

Potential pitfalls

Financial disadvantage to clients Dr Beena Raschkes, GP, NHS Tayside says she has patients who would be financially disadvantaged if they returned to work on reduced hours instead of receiving sick pay for the whole week. This needs to be taken into consideration by employers when agreeing a return to work plan.

Insufficient information on fit note

Linda Bell, consultant occupational health physician from a Dunfermline-based occupational health provider, Business Medical, says that GPs generally have had no training in occupational health, don't know the specific workplace, the demands of the job and the scope for adaptations, whereas occupational health professionals do, and can visit the worksite and talk to the relevant managers. Business Medical reports an increase in referrals, as employers try to assess what adaptations are needed.

How will this affect workplace counsellors?

By workplace counselling, I mean where the counselling is paid for by the employer. The workplace counsellor may be directly employed by the client's employer or work freelance for a national Employee Assistance Programme (EAP) provider like Rowan.

As a workplace counsellor, I am not usually asked to provide any reports for management. There is one employer, however, who, when they make a management referral, asks the counsellor to provide a report with suggestions for how the employer can facilitate a return to work. I discuss this with the client and ask them for suggestions. These can include a phased return, or amended duties. Sometimes I find that clients are not aware of these options. They believe that they can only return to work once they are a hundred per cent fit and able to return full time to all their duties.

I believe that part of our educative role as workplace counsellors, is to know the points below and convey them to our clients, when appropriate:

- the common ways that employers can help someone return to work
- that employers are supposed to conduct a return-to-work interview with clients before or when they return from sickness absence. The purpose is to discuss how the employer can support the client in their return, and may include exploring the options recommended on the fit note. The workplace counsellor can usefully discuss options with the client beforehand, helping them work out what is best for them, so that they can go into their return to work interview able to put forward their own suggestions. I often find that clients welcome the opportunity to use counselling sessions to prepare for such interviews.
- employers are not obliged to follow the recommendations on the fit note – clients may assume that employers must follow the doctor's suggestions. We can help them be realistic, since the employer only has a duty to consider the recommendations.
- that returning to work can be beneficial to mental health.

How directive or educational should workplace counsellors be?

Some workplace counsellors may be completely non-directive: even when a client is off work, they would not raise return to work unless the client did so.

Others, myself included, would ask the client what would support them to return to work. Sometimes the reply is, "I can't even think about that yet," in which case I concentrate on what is figural for the client (for example, talking about personal issues, or building their confidence by tackling simple tasks, such as leaving the house).

My aim when I raise the question is to help prepare the client for their return-to-work interview, to empower them to take some control of the situation by stating their needs and giving their employer options. Taking a measure of control relieves stress, which often results from feeling out of control. Considering practical steps towards returning to work, helps the client break it down into manageable chunks.

For one client the first step was simply driving into the work car park, sitting in the car and driving away; that in itself was a challenge. He gradually built up to going inside, having coffee with a colleague and so on until he felt ready to speak to a manager and then have a phased return. Like any other issue which clients bring, I cannot give them solutions but I can help them break down the problem and come up with their own creative solutions, to support themselves and access support from others.

Conclusion

The new fit note allows the GP to provide more information for employers on what adjustments may help the employee return to work. The quality of this information will be limited by the GP's knowledge of the workplace, but it is an improvement on the old sick note, which made no recommendations at all. It encourages employers to discuss with employees how best to support their return to work.

Workplace counsellors need to know the options available and to encourage clients to consider whether a speedy return to work is in their best interests, and, if so, what would support them returning to work.

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Getting it Right for Every Child

scotland's vision for all children and young people

Marilyn Nicholl

Marilyn Nicholl discusses the national context for GIRFEC and its implementation in Edinburgh.

Attending to the principles and values of *Getting it right for every child* (GIRFEC) is not only for those working as counsellors or therapists in schools, in voluntary sector organisations or in the NHS; it has relevance for all those who work to support families in our broader society and in particular for those who work with the most vulnerable individuals.

Therapy often implies a one-to-one context, in a boundaried, contained space, but of course we do not work in isolation and this paper invites us to consider our work alongside the Scottish Government's national vision of "building a society where our children are safe, nurtured, achieving, healthy, active, responsible and respected, and included."[1]

Getting it right for every child is part of Scotland's response to the UN *Convention on the Rights of the Child*. GIRFEC implementation is already underway in at least nine community planning partnership (CPP) areas. The Scottish Government is encouraging every CPP to commit to implementation, so that it becomes the foundation for all work which affects children and young people, including work in adult services where parents and carers are involved.

What do we mean by "getting it right for every child"? We mean culture change, systems change and practice change. The policy will help services work better in partnership, towards improved outcomes. Systems change means striving to reduce bureaucracy, working with shared paperwork and shared aims. Alongside this, there is an important focus on culture change – a focus on how we manage and engage in our work together as we implement changes in practice. It asks us to look at how we are attached to (and are loyal to) the concepts and formulas which underpin our ways of being when we are at work – and to be open to changing them.

In a move from 'doing to…' to 'doing with…' GIRFEC is about an approach which seeks to promote all aspects of growth and well-being. That includes mental health, which is increasingly understood as a fundamental building block of healthy development and sound education for the young. A key element of the approach is to include children, young people and their families as partners in a process, partners who have a right for their view to be part of the decision-making around supportive interventions.

Emotional intelligence is recognised as being key not only to the well being of children and young people but also to the staff who work with them. Getting it right for every child aims to bring solution focussed and emotionally intelligent practices more strongly into everyday communications.

So how can we engage with GIRFEC?

Whether we work as single workers or within an agency, we can use the principles and guidelines of GIRFEC to sustain our work wherever it relates to children and young people or to adults who are parents/carers. And by working collaboratively within our communities the aim is to focus resources most effectively and where they are most needed.

Getting it right for every child means developing a shared understanding of what helps, so that we can:

- build solutions with and around children and families;
- enable children, young people and their families to get the help they need when they need it; and
- ensure practitioners and agencies work together and support each other to best effect.

GIRFEC in Edinburgh

Community planning partnerships are in different states of readiness to introduce GIRFEC as the basis for their service provision. Highland was the Scottish Government's first GIRFEC pathfinder and helped shape, develop and test the GIRFEC model and its implementation. Edinburgh University's evaluation of the positive progress they have achieved in supporting children and young people has helped to inform CPPs[2]

Edinburgh has also taken a strong lead in strategic level partnership, working as a fundamental element of the move to more integrative services.

There are a number of areas within the city with a history of strong multi-agency working and the Edinburgh partnership aims to consolidate such areas of best practice and facilitate their extension across the city. There is some way to go to establish the most effective multi-agency practice – and the context is one of national, financial restraints. Edinburgh is, however, determined to rise to these challenges and to support staff with differing professional and cultural traditions in working together to provide supports from within a shared set of principles and using a common language.

The aim is for a city wide, solution-focussed approach with the following stakeholders:

- Children, young people and their families
- The City of Edinburgh Council
- Scottish Council for Independent Schools
- Scottish Children's Reporter Administration

Operational Policies: How do we all work together?

As in other authorities the implementation of *Getting it right for every child* in Edinburgh will be founded on 10 core components which can be applied in any setting and in any circumstance, with a focus on outcomes (see additional information section). These are at the base of putting GIRFEC into practice and can provide a benchmark against which one will be able to determine the development of best practice in one's own agency.

The Edinburgh approach builds from the foundations available in the family, in the community and universal services. Examples of proposed shared paperwork which agencies are encouraged to use are available to download. Important basic concepts in the Edinburgh model include:

- A named person, who will act as the initial point of contact in universal services to coordinate services if there are concerns for a pregnant mother, child or young person. That person will be: – From pregnancy to 11 days: midwife – From 11 days to primary school entry: health visitor
- Primary school and secondary school: head teacher
- A lead professional, who will be identified if the complexity of needs is greater, and who will take up overall co-ordination when several agencies are working together to assist a child or young person.

As GIRFEC rolls out across Edinburgh, a range of multi-agency training opportunities is available to support the implementation.

GIRFEC across Scotland: Will we need to change?

Wherever you are located and whatever your CPP's particular 'take' on GIRFEC, the aim will be to build on existing best practice. It may well be that your agency's current codes of practice already reflect GIRFEC values. To determine what you may need to further develop, in terms of your agency's rules and procedures of professional conduct, there are national and local GIRFEC guidelines (see additional info. section). Relevant adjustments may be made to your current procedures, depending on the services and client groups your agency represents.

The *Getting it right for every child* practice model promotes recording information consistently, in a way that allows it to be collated when needed to provide a shared understanding of the needs of the child or young person. Confidentiality is always an important consideration for agencies in their client work. Within this framework of confidentiality, agencies will wish to look at how informed consent by service users may improve the support they get, by allowing a careful sharing of information with other agencies. In the question of consent, the child or young person's safety remain paramount and it is important to note that current Child Protection Procedures remain unchanged.

Shared values and principles underpin the approach and agencies may want to ensure that their policy documents demonstrate a consideration of GIRFEC. These build on the Children's Charter and reflect legislation, standards, procedures and professional expertise, bringing meaning and relevance at a practice level to single-agency, multi-agency and inter-agency working. There is a common platform for working with children and young people which all practitioners and professionals can draw from, as all are working towards the same outcomes.

The theories which inform much of our own listening based and client-centred practice are echoed in the current values and principles which inform GIRFEC implementation. Moves are taking place to increase active participation with service users. GIRFEC is about multi-agency working and about systems and practice change, but essentially it is also about building relationships which make it easier to provide help when it is needed.

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[1] www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec

[2] www.scotland.gov.uk/Publications/2009/11/20094407/0

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UN Convention of the Rights of the Child
www.unicef.org/crc/

Getting it Right for every child in Edinburgh:
www.edinburgh.gov.uk/GIRFEC

Edinburgh Central Implementation Team.
E-mail: GIRFEC@edinburgh.gov.uk

For the latest news on the Scottish Government's national implementation plan, including new implementation guidance:
www.scotland.gov.uk/gettingitright

GIRFEC Learning Community:
www.scotland.gov.uk/gettingitright/

LearningCommunity Practitioner Pages:
www.scotland.gov.uk/gettingitright/PractitionerPages

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Public perceptions

of the credibility and usefulness of CBT, person-centred therapy and counselling

John McLeod

John McLeod and
Andrew Sweeting

ABSTRACT

There is considerable evidence that people seeking therapy express preferences for different approaches and intervention styles, and that these preferences have an impact on both the development of the therapeutic alliance, and eventual outcome. The aims of this study were to examine perceptions in Scotland's general population of the credibility and usefulness of forms of therapy that are widely available within that cultural setting.

Participants (28) were asked to read expert-generated descriptions of cognitive behavioural therapy (CBT), person-centred therapy, and counselling, and to indicate their preferences for each approach, using rating scales validated in previous studies. Participants were also invited to comment on the reasons for their choices – these open-ended responses were subjected to thematic analysis. The results of this survey showed that participants rated CBT and counselling higher than person-centred therapy. Overall, counselling was the most favoured option.

A variety of reasons were given to account for these choices. The study suggests there is support for all three of the therapeutic approaches examined. To ensure service users are provided with appropriate choices, it may be important for policy-makers to ensure that a range of therapy options are available. It could be significant that counselling, which was described in this study as a flexible approach that incorporated both problem-solving and relational elements, was patricularly highly valued by participants. It is possible that client predilections are better reflected in specific elements of therapy, rather than therapy approaches as a whole.

This was an exploratory study, carried out on a relatively small sample. Further large-scale replication is required to determine the general applicability of the findings, and more research needed to examine the questions raised in greater detail.

Keywords: clients, cognitive behavioural therapy, counselling, credibility, person-centred, policy, preferences.

It is clear that clients have varying views about the credibility of different models of counselling and psychotherapy, and have preferences about which approaches they choose. The diversity of private practice in psychotherapy provides one form of evidence about client preferences. Further evidence can be found on a body of research into client preferences, carried out over a 20 year period. For example, in one well-known UK study of counselling in primary care, depressed patients were given the option of choosing between non-directive counselling and CBT (King et al., 2000). Of those patients who specifically wanted one of these two therapies, around 40 percent opted for non-directive counselling, while 60 percent chose CBT. In Sweden, Bragesjo et al. (2004) examined the opinions of a random sample of the public on the credibility of three different models of psychological therapy: psychodynamic, cognitive, and cognitive behavioural therapy. Bragesjo et al. (2004) found strong preferences for each of these approaches in different sub-groups of the population included in their survey. In a recent review of research into client preferences, Swift and Callahan (2009) found that clients who received a preferred therapy gained had better outcomes than those who did not, and were less likely to drop out of therapy. In addition, studies by Constantino et al. (2007) and Patterson et al. (2008) found that clients who received their preferred therapy reported higher levels of therapeutic alliance with their counsellor.

The issue of client preference is particularly relevant in the light of recent developments in the provision of counselling and psychotherapy. In the UK, there has been strong pressure of NHS-funded counselling

and psychotherapy services to deliver only those forms of therapy that are supported by National Institute for Health and Clinical Excellence (NICE) or the Scottish Intercollegiate Guideline Network (SIGN). This approach to policy decision-making has had the effect of marginalising client preferences in favour of evidence derived from randomised trial studies. Furthermore, there has been a great deal of favourable media coverage in recent years of cognitive behavioural therapy. It is not clear whether this publicity has heightened client preferences for this form of therapy.

Method

Participants. A sample of 28 individuals (age range 19–65; 64 per cent female; all ethnic white) living in Glasgow and the east of Scotland took part. Most of them (78.6 per cent) had no previous experience with psychological therapy; 14.3 per cent had received counselling and 7.1 percent. CBT. None had received person-centred therapy.

Descriptions of psychotherapy approach. Participants were invited to read expert-authored written descriptions (1200 words) of each therapy approach. The descriptions of CBT and person-centred/humanistic therapy were taken from the service user document prepared as part of the Department of Health (England) psychotherapy competencies project based at the Centre for Outcomes Research and Effectiveness at University College London (available online at: www.ucl.ac.uk/clinical-psychology/CORE/CBT_Framework.htm). The Department of Health description of humanistic therapy was re-titled "person-centred therapy" to reflect the fact that person-centred is by far the most widely available humanistic approach available in Scotland. A description of counselling, using the same Department of Health format, was written specifically for this study by two leading figures in the counselling profession. Each description began with a brief description of the psychotherapy approach, outlining its rationale, then describing what the therapy involved, what the experience would be like, how long the treatment might last and how the therapy would end.

Credibility ratings. A 5-point rating scales was used (where a higher rating reflected a more positive view), developed by Bragesjo et al. (2004). A series of scales asked participants to indicate their perceptions of how helpful, difficult and well-founded each approach was, whether they would use it themselves, and whether they would recommend it to another person.

Qualitative interview. A brief open-ended interview included questions about how participants reacted to descriptions of the approaches, the reasons behind their preferences, and their views on the rating scales.

Procedure. A snowballing technique was used to recruit individuals known to the researcher (AS), as well as individuals known to them. Participants were given a written instruction sheet explaining the reason for the research and informing them of the confidentiality of the responses they provide. The order of these descriptions was rotated so that each description was the first read an equal number of times. Further information about the scales used in the study, and the descriptions, can be obtained from JMcL.

Results

Information on participant perceptions of key aspects of the relative credibility of each therapy approach is shown in Table 1. A series of paired sample tests were carried out to examine differences in the credibility ratings between the different psychotherapy approaches. These analyses indicated that counselling and CBT were regarded as equally credible, and that both were regarded as more credible than person-centred therapy.

A similar pattern was found for the level of how demanding each approach seemed, the likelihood that the person would choose the approach, and likelihood of recommending it to someone else. Counselling was viewed as being significantly more helpful than each of the other approaches.

Table 1. Credibility of different therapy approaches

	CBT	Person-centred	Counselling
Credibility of theory ('well-founded')	4.11	3.29	3.36
How demanding	3.43	2.79	3.07
How helpful	3.71	3.54	4.25
Likely to choose for myself	3.57	3.18	3.93
Recommend to someone else	3.64	3.25	3.93

Ratings on 1-5 scale, where 5 = positive agreement / endorsement

After reading all of the descriptions, participants were asked to sum up their views by making a choice about which one they would personally prefer, if they needed help. In response to this question, 54 per cent indicated a preference for counselling, 32 per cent CBT, 11 per cent person-centred, and 3 per cent had no preference.

Information about the reasons for these preferences emerged from the qualitative interviews. Most interviewees reported that they were split between counselling and CBT, because both approaches made sense to them. Counselling was described as attractive on the grounds that "it just makes sense". Those drawn to CBT described it as a very concrete therapy which seemed grounded in psychological theory. Interviewees were generally unimpressed with the rationale for person-centred therapy, which was characterised by several participants using terms such as "wishy washy". Asked about the clarity and usefulness of the written descriptions most felt that the descriptions were unhelpful and confusing. Several participants referred to difficulty in understanding the material, with one person stating that they "had been put off psychotherapy" by what they had read. The length of the descriptions added to the difficulty in understanding. Other participants felt some of the material was patronising. One participant specifically mentioned a line from the CBT description which stated that "the therapist should give you the feeling that he knows what life is like", citing it as an example of the patronising tone of the material that they had read. Participants were generally positive about the rating scales used in the study.

Discussion

It is important to interpret the findings of the study with caution. A small sample was used, and it is possible that a larger, more representative study of the Scottish population, might generate different results. In particular, the views of ethnic minority citizens and older people were not included, and data on educational level and social class were not collected. The sample size precluded meaningful analysis of preferences in terms of gender, age, and previous experience of therapy. Also, the procedures of the study allowed only a limited amount of time for the qualitative interviews – it seems likely that a more extended interview would allow further themes to be identified. Finally, it is essential to keep in mind that the methodology employed in this study was grounded in participant responses to written information, and that providing information about therapy in different media (for example, video or the internet), or using a more personalised written format, might have elicited different views.

Despite these limitations, the results of the study do appear to confirm the findings of earlier work, that different people are looking for quite different things from therapy. As with the Bragesjo et al.

(2004), it emerged that many people are convinced by the rationale for CBT. However, in both the present study and in Bragesjo et al. a significant proportion of members of the public expressed preferences for non-CBT approaches to therapy. In the present study, there was a particularly high level of approval for counselling defined as a flexible, client-focused approach that encompassed both structured and exploratory elements.

The interviews provided evidence that the written descriptions of therapy approaches they were shown did not appear to be well received. It is interesting that person-centred/humanistic therapy, which in practise is experienced as highly empowering by many people, was seen as vague and ill-defined when presented in a written format. It may also be that service users find it hard to conceptualise therapy models or 'packages' as a whole, and that their preferences are better captured through rating scales that break down therapy into discrete activities (see, for example, Berg, Sandahl and Clinton, 2008).

In conclusion, the findings of this study suggest that members of the public have active preferences for the types of therapy they regard as being potentially most useful for them as individuals, and that the therapy professional community is not very effective in communicating with the public about what they have to offer. This has implications for policy-making and for the structure and organisation of counselling and psychotherapy services. The methodology developed by Bragesjo et al. (2004) and Berg et al. (2008) represent robust and cost-effective means of collecting information about preferences for therapy, and provide a basis for further work on this topic. In the longer term, it is essential that this programme of inquiry should address questions around how therapy services, and individual practitioners, might most meaningfully engage with and build on client preferences in order to develop the most highly effective therapy.

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Counselling Skills Module 2

a personal account

Theresa Keicher

At the end of Counselling skills module 2 was the dreaded presentation! I did not want to read my assessment out aloud and wondered how I could present what I had learned over the previous ten weeks. This account is how I felt best able to describe my learning.

When I was looking out of my window I noticed the trees at the bottom of the garden and I began to think of my life like a tree.

When we started module 2 the leaves were nice and plump still on the branches of the trees and there were colourful shrubs and flowers all around.

Over the past 10 weeks I have watched as the trees have changed from green to yellow, orange, golden and brown until finally with the wind giving a large gust the leaves have fallen off the braches and probably much to the annoyance of my neighbours they have blown into their gardens.

This seasonal change is much like the process of change I feel I have gone through and continually go through. At the beginning of the module I had my leaves (defences) to cover my branches (feelings) to save them from being scorched by the sun (outside influences and past experiences).

Over the ten weeks these leaves have been blown around and gradually dropped off during the middle phase. This has meant that the branches or my feelings have been exposed. But these actions are not the end. For me they symbolise all the twists and turns that my life has taken. They reveal the losses and the gains that I experience and I would relate them to the little nodules, bumps and twigs on the branches. They all had leaves to cover them and it is not until the leaves go that I can see what is really beneath them. You can take two separate twigs, similar in size, both coming from the same branch but they are both completely different. Not only do they have different little twists and turns but they are also of a different texture and shade.

The trees have to have bare branches for a while in order for new growth to take place. They have to be open to the elements; they have to endure the wind and the rain, the sleet and the snow as well as the unnerving calmness. All these harsh elements help it to grow stronger.

The ending for me is the realisation that if you connect the twig to the branch to the trunk of the tree and follow it down to the root system what you will find is not just one single root keeping it steady but an extensive even multitude of strong tendrils that ground the tree, that stabilise it and keep it steadfast to endure all of those elements that the tree and it's branches are exposed to.

I see these tendrils as the people that I meet who hold me steady and help me stabilise myself so that when the next season begins I am stronger that the last season. I am older, more mature and can hopefully show my new blossom as I have done in the past. The tree may look vulnerable when it is bare but with its good root system it will come back more vibrant and stronger than before.

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Gazette

Details of all events are on the COSCA website: **www.cosca.org.uk**
Please contact Marilyn Cunningham, COSCA Administrator, for further details on any of the events below:
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2010

20 August
COSCA Diploma Trainers/Providers Forum
Stirling

29 September
COSCA Annual General Meeting
Stirling

30 September
Deadline for receipt of COSCA Trainer and Counsellor Accreditation applications

23 November
COSCA 7th Counselling Research Dialogue
Stirling

December (tbc)
COSCA Trainer and Counsellor Accreditation Workshops

2011

10 March
COSCA Ethical Seminar
Stirling

Vision and Purpose

As the professional body for counselling and psychotherapy in Scotland, COSCA seeks to advance all forms of counselling and psychotherapy and use of counselling skills by promoting best practice and through the delivery of a range of sustainable services.

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